Medical Corps Newsletter

AUTUMN 2019

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From the Corps Chief...

RDML James L. Hancock
Chief, Medical Corps

Shipmates,

It is with great honor and humility that I begin service as the 13th Chief of the Medical Corps. Having served alongside many of you, it's the privilege of a lifetime to be asked to represent our Corps. I would be remise if I did not acknowledge our brothers and sisters who are forward deployed, ready to receive casualties in ongoing kinetic operations. We have folks out on COMFORT bringing the best medicine in the world to the humanitarian crises happening within our own hemisphere. Our research and training commands are preparing for the challenges of tomorrow. Many of you are hospital-based physicians honing your skills and ensuring the next generation of Navy Physicians will maintain our legacy.

Our Nation has always asked our Navy's Physicians to bring the highest standards of medicine to some of the most challenging environments on, below, and above the sea. While shifting strategic, financial, and political realities have introduced new internal challenges to our mission, I could not be more proud to be a part of our great institution, performing with unprecedented results in high-quality, high-reliability care. I envy those of you who are starting your careers. The near-future will include untold opportunities for original thought and development of our military healthcare system.

That said, I am aware that this uncertainty adds stress to an already challenging mission for all of us. My office will do its utmost to keep you informed, but as you are likely aware, many of the specifics of the best way forward are still being deliberated at the highest levels. Often times the worst rumors will gain the most traction in the absence of information, so I would ask that you do your very best to not perpetuate this cycle. Instead, ask the hard questions of your leadership team and help them keep lines of communication open up and down the chain of command.

As a physician you are the natural leader of the clinical team, and that team will learn how to react to any uncertainty from you. I am confident you are the right leader to explain that information that was once accurate may change as time evolves and more informed decisions are made. You will be critical in ensuring that we remain flexible to meet the mission.

We and those before us have earned the respect and reputation as doctors capable of delivering high quality medical care anywhere, anytime, regardless of circumstance. The historic successes that we have enjoyed have now become the expected standard. As the Department of Defense reshapes to increase lethality, military physicians have to ask ourselves how we fit into "lethality"? I would hope you would agree that being lethal as a physician is not an optimal goal!

As military physicians, I think we can agree that our ability to save lives on the battlefield makes the overall force more lethal. Combat survivability will almost certainly require a very different skillset in contested airspace within an at-sea battle. Assumptions of clear communication channels and unchallenged golden-hour medevacs will almost certainly not hold true. Our charge is to foresee these challenges and prepare accordingly.

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New Reserve Deputy Chief!

RDML Pamela Miller
Reserve Deputy Chief, Medical Corps

Rear Adm. Pamela Miller is a native of Muscatine, Iowa and was commissioned an ensign in the Navy Reserve Nurse Corps in 1989 following graduation from the University of Iowa where she earned a Bachelor of Science and Master of Arts in Nursing. In 1995, she was selected for the Navy Health Professionals Scholarship Program, and commissioned as an ensign in the medical corps and attended medical school at Des Moines University, Des Moines, Iowa earning both a Doctorate in Osteopathic Medicine and Master's in Healthcare Administration. She completed a transitional internship and residency in emergency medicine at Naval Medical Center San Diego, California graduating in June 2005. She is a 2016 graduate of the distance education program at the Naval War College, and in 2018 she completed Phase II of the Joint Professional Military Education at Joint Forces Staff College, Joint Combined Warfighting School Hybrid program in Norfolk, Virginia.

As a nurse corps officer, she served with Fleet Hospitals 22 and 23 in numerous assignments to include officer in charge of a Primus Detachment. As a medical corps officer, her assignments include senior medical officer, 1st Medical Battalion and deputy group surgeon, 1st Marine Logistics Group (MLG), Camp Pendleton, California. During this time 1st Medical Battalion prepared and deployed the first Forward Resuscitative Surgical System teams into combat operations. She then served as a staff physician in the emergency department at Naval Hospital Camp Lejeune, North Carolina where she deployed in support of Operation Enduring Freedom under Combat Logistics Regiment 15, Camp Pendleton, California assigned to the surgical facility in Al Taqaddum, Iraq as officer in charge of the mobile shock trauma platoon. Upon return, she served as the 2d MLG surgeon, Camp Lejeune, North Carolina.

Leadership assignments included deputy group surgeon, 4th MLG, Marine Forces Reserve; senior medical executive, Operational Health Support Unit-Dallas and executive officer, 4th Medical Battalion, 4th MLG, MAFORRES. Miller mobilized May 2014 to July 2016 as force surgeon, U.S. Marine Corps Forces, Central Command, and concurrently served as the reserve component operational medicine specialty leader. From December 2016 to December 2018 she was commanding officer, Expeditionary Medical Facility Dallas One where she led a command comprised of over 700 Sailors in 19 detachments across eight states. She most recently served as deputy chief of staff, Reserve Component, Navy Medicine West from December 2018 to October 2019. Miller is currently serving as reserve fleet surgeon, U.S. Fleet Forces Command.

Miller has completed numerous leadership courses to include the Navy Senior Leader Seminar, Medical Strategic Leadership Program, Joint Senior Medical Leaders Course, Naval Leadership and Ethics Center PCO/PXO courses and Executive Officer Course, Marine Forces Reserve. Miller is a Fleet Marine Force Warfare Qualified Officer whose personal awards include the Legion of Merit (two awards), Meritorious Service Medal (four awards), Navy Achievement Medal (two awards) and the Military Outstanding Volunteer Service Medal.

JUNIOR OPERATIONAL OFFICER SPOTLIGHT

LT Steven Bradley (right) in Grenada, performing a preoperative evaluation with CDR Mark Johnson, General Surgeon and Comfort DSS (middle) and LCDR Don Lucas, Pediatric Surgeon (left) Photo Credit: USNS Comfort PAO

LT Steven Bradley is a board certified Anesthesiologist currently deployed on the USNS Comfort in support of Enduring Promise 2019. As a recipient of the Financial Assistance Program, he trained out-of-service, medical school at Howard University in Washington, D.C., and residency at the University of Chicago Medical Center. After completing residency in 2018, he checked into Naval Medical Center Portsmouth as a staff anesthesiologist, and in March of 2019, he had the opportunity to explore the variety of practice that comes with a career in the Navy Medical Corps.

"Shortly after passing oral boards, I was able to go TAD to Naval Hospital Guantanamo Bay in Cuba. I never thought that I would be practicing anesthesia at GTMO." He provided coverage so the Anesthesiologist stationed on the island could return to the States for board exams and leave.

After returning to NMCP in May, news rapidly spread of a Humanitarian Aid deployment for the USNS Comfort. Billeted to the Comfort as a critical-core staff member, LT Bradley soon found himself packing a sea bag and preparing for 5-months at sea. "As the division officer for the anesthesiology department, I checked into the ship a month before we were scheduled to leave. My responsibilities included evaluating the anesthesia equipment and supplies on hand and determining what needed to be ordered. While underway, I work closely with the 7 surgeons embarked, and I coordinate with the anesthesia staff members, (3

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SENIOR OPERATIONAL MEDICAL OFFICER ARTICLE

Submitted by: CAPT Michael McGinnis, MC, USN
Fleet Surgeon, Commander US SIXTH Fleet
Force Surgeon, NAVAF/NAVEUR

Medical Corps,

Greetings from the U.S. Naval Forces Europe, U.S. Naval Forces Africa, and U.S. SIXTH Fleet (CNE-CNA-C6F) team headquartered in Naples, Italy. CNE-CNA is the Echelon 2 Navy component command for two geographic combatant commanders (CCDRs). Our maritime headquarters is a combined battle staff that supports both EUCOM and AFRICOM and the water space surrounding both (U.S. SIXTH Fleet, CTF 6). Our area of operations (AO) covers 101 of 195 countries in the world.

Here at CNE-CNA-C6F we are focused on the operational level of war and readiness to conduct high end warfare with near peer competitors. Great power competition is in play for both Europe and Africa. Operationally we are focused on a resurgent Russia and a globally engaged China. We have been the most kinetic Fleet in the Navy in delivering lethal fires for effect. We have an incredible mission with extensive opportunity – fortunately, we have an incredibly talented team in Force Medical to support our Commander.

ADM Foggo's priorities are nested under the national defense strategy and the priorities of the theater CCDRs:

Operate at and from the sea. As a Naval force we will assert our will at the time and tempo of our choosing. We employ this through distributed maritime operations (DMO). This concept employs ships as a platform that is integrated in the Fleet battlespace via mission command and networks, deemphasizing the strike group as the fundamental warfighting element. For example, we distributed the simultaneous employment of IWO JIMA's amphibious ready group ships in the Black Sea, Mediterranean and FIFTH Fleet.

Increase warfighting readiness. Dynamic force employment is another concept we are implementing where the Fleet is strategically predictable, but operationally unpredictable. As an example, within a month of the HARRY S TRUMAN returning from deployment to the Mediterranean, she was redeployed to the High North and participated in TRIDENT JUNCTURE. Her participation in NATO's largest maritime exercise in 40 years was the first time a carrier had been above the Arctic Circle since the collapse of the Soviet Union. Strategically predictable (stronger together with our NATO allies) but operationally unpredictable (rapid redeployment).

Improve capabilities of our allies and strengthen partnerships. We do this by participating in NATO exercises and working together to leverage individual country strengths in integrated continental defense.

In Force Medical we approach Health Services Support for our Commander's lines of effort by:

Setting the theater medically. We are focused on medically preparing the theater for the full spectrum of warfare from tactical to strategic. Our advocacy spans from the agile and platform agnostic role 2 damage control surgery team and BUMED's program of record development to the expeditionary medical facility capability with personnel and gear ready for a High North cold weather fight. We look to Navy Medicine to be ready to deliver the capabilities required for our operational plans. As our SG highlights, we

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(Corps Chief Message, Continued from page 1)

When I am asked how Navy doctors increase the lethality of the force, I explain that Navy Medicine increases lethality by increasing survivability and that increased survivability is defined as ZERO preventable deaths on the battlefield. Quite simply, our mission is to deliver Marines, Sailors, Soldiers, Airman and Coastguardsman to the fight in peak mental and physical health with maximal resiliency, and then provide state of the art medical care if they are injured.

Shipmates, we must be tireless in our preparation. We must remain relentlessly dissatisfied with the status quo. We must train ourselves morally, mentally, and physically to be ready when called upon. We must endeavor to ensure that the care we deliver is informed by the most relevant research and society guidelines. We must share our thoughts and experiences, and teach others 'how to think' from an operational perspective. Extend your sphere of influence by training the Corpsmen and Nurses around you to 'think critically' and help to solve problems. While we will not be able to predict what the challenge will be, or even who will face it - we can say with certainty that our Sailors' or Marines' lives will depend on our ability to adapt and overcome.

I have NO DOUBT our Medical Corps is ready for this challenge. I am YOUR Corps Chief, so please do not hesitate to reach out to me directly via e-mail at James.Hancock@USMC.mil. I want to hear from you!

- JLH

The Franklin's Four Doctors

André B. Sobocinski, Historian, BUMED

On the morning of March 19, 1945, during operations off Kobe, Japan, *USS Franklin's* (CV-13) hangar deck was hit by two enemy semi-armor piercing bombs leading to a raging fire and detonation of the ship's ordnance.

Despite the recurrent blasts and poisonous fumes penetrating through the compartments, Lt. Cmdr. George Fox, MC, USN, remained at his battle station sick bay. Steadfast, Fox continued to administer to casualties until becoming asphyxiated in the dense, suffocating smoke.

On the third deck, just below the warrant officers' wardroom, Navy physicians Cmdr. Francis Smith and Lt. Cmdr. James Fuelling found themselves trapped in a smoke-filled compartment. With calm, cool demeanor, they worked on quelling the panic among the other trapped men. Once an escape route was discovered—they succeeded in evacuating all personnel from the compartment and proceeded to the flight deck where they administered to the wounded.

Flight surgeon Lt. Cmdr. Samuel Sherman had been on the flight deck throughout the ordeal, exposed to numerous bombs, rockets and enemy aircraft fire. With disregard for his own safety, Sherman set up a sick bay and a dressing station and began to administer treatment to injured personnel. As Sherman later related, "[We] had hundreds and hundreds of patients, obviously more than I could possibly treat. Therefore, the most important thing for me to do was triage—separating the seriously wounded from the not-so-seriously wounded. We'd arranged for evacuation of the serious ones to the cruiser *Sante Fe* [CL-60], which had a very well-equipped sick bay and was standing alongside."

Lt. Cmdr. Samuel Sherman, MC, USN, heroic flight surgeon aboard the *Franklin*. BUMED Archives

The attack on the *Franklin* ultimately lead to deaths of 37 officers and 704 men and the wounding of 206. But without the presence of mind and courageous actions of these four doctors, there is no doubt that many more would have died.

Fox (posthumously), Fuelling, and Sherman would each be awarded the Navy Cross for their acts of heroism aboard the *Franklin*.

Sources:
Fox, George. Navy Cross Citation. "The Hall of Valor Project." The Military Times. Retrieved from: https://valor.militarytimes.com/hero.

Fuelling, James. Navy Cross Citation. "The Hall of Valor Project." The Military Times. Retrieved from: https://valor.militarytimes.com/hero.

Herman, Jan. *Battle Station Sick Bay: Navy Medicine in World War II*. Annapolis, MD: Naval Institute Press, 1997.

Administrative History Section, BUMED. "Cumulative Report, USS *Franklin* (CV-13)." The United States Navy Medical Department Historical Data Series, World War II Ships. Volume III: Aircraft Carriers, 1946.

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must collectively ensure we are planning and ready for the future fight.

Our OCONUS facilities are prepositioned medical platforms in support of OPLAN requirements. Our collective flag leadership view our hospitals in Europe as prepositioned medical platforms that enable day to day power projection and readiness in support of OPLAN requirements. In Europe we successfully registered the requirement for preserving USNH Naples and Sigonella as hospital platforms, but we understand the discussion between sunk costs supporting readiness and desire for cost savings is never over.

Coordinating and employing NAVEUR MTF staff in theater exercises and operations. I work closely with the NAVEUR hospital COs (CAPT Archila in Rota, CAPT Knittig in Naples, CAPT Todd in Sigonella) and we are aligned. We preferentially employ and deploy their hospital staff in support of missions in our AO to include exercises with NATO, health security cooperation operations in Africa, and mission support for operational platforms to include ships, Aegis Ashore in Romania and Poland, and our Expeditionary Medical Facility in Djibouti.

A few "asks" from the Fleet:

Keep your cutlass sharp. As our former C6F and current USFFC Commander emphasized, focus on being excellent for what the Navy needs of you. Be ready for the call. Remember medical is supporting and our line commanders are the supported. Be familiar with which operational unit you support either directly or by platform.

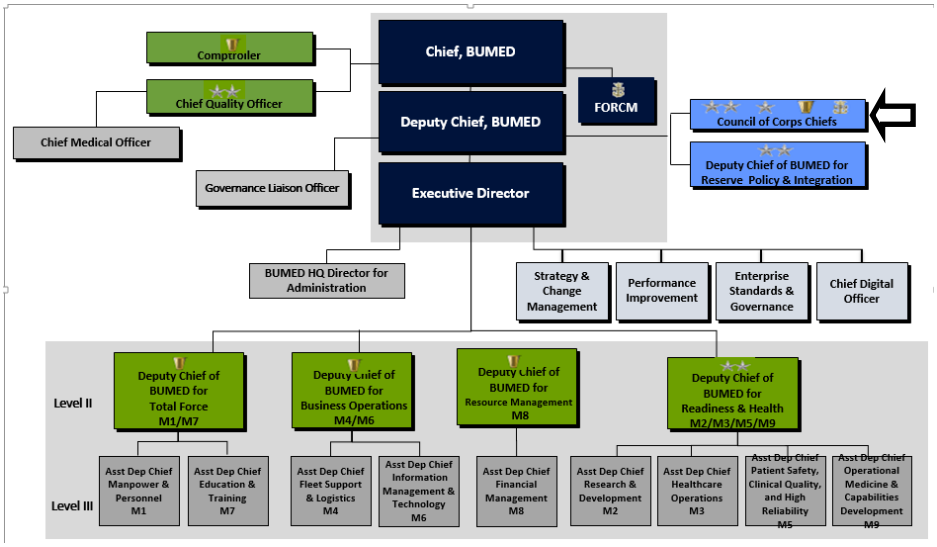
Mentor the next Sailor up. As you explore your career plan, actively seek mentorship. Leaders, ensure your staff are receiving guidance and career development boards. Your specialty leader, your detailer and our OOMC are fantastic resources for any questions you may have regarding career development.

Embrace the operational Navy and Marine Corps. Navy Medicine is a global healthcare enterprise with incredible opportunities both inside/outside the MTF and CONUS. I'm a great advocate for looking for operational and OCONUS positions. The earlier in your career and the more junior you are, the greater the diversity of jobs available to you. Being operational is demanding but incredibly rewarding.

The Fleet and your Navy adventure awaits. **Remember, we are "One Navy Medicine!"**

BUMED Organizational Structure, Where does the Corps Chief's Office fit in?

The Navy Surgeon General (SG) is the principle medical advisor to the Chief of Naval Operations (CNO). Simultaneously, the SG also serves as the Chief of the Bureau Medicine and Surgery (BUMED). The Department of the Navy is fiscally organized into several 'Budget Submitting Offices' or BSOs. BUMED is BSO-18 and responsible for approximately 75% of Navy Medical Corps Personnel. BSO-27 (Marine Corps) has the second most medical officers assigned, followed by BSO-60 (Atlantic Fleet), BSO -70 (Pacific Fleet), and BSO-88 (Special Warfare). Operational Officers are familiar with 'being owned' by the Marine Corps or Fleet, which simply means the funding for their billets comes from these non-BUMED BSOs.


Comptroller
Chief Quality Officer
Chief Medical Officer
Governance Liaison Officer
Chief, BUMED
Deputy Chief, BUMED
Executive Director
FORCM
Council of Corps Chiefs
Deputy Chief of BUMED for Reserve Policy & Integration
BUMED HQ Director for Administration
Strategy & Change Management
Performance Improvement
Enterprise Standards & Governance
Chief Digital Officer
Level II
Deputy Chief of BUMED for Total Force M1/M7
Deputy Chief of BUMED for Business Operations M4/M6
Deputy Chief of BUMED for Resource Management M8
Deputy Chief of BUMED for Readiness & Health M2/M3/M5/M9
Level III
Asst Dep Chief Manpower & Personnel M1
Asst Dep Chief Education & Training M7
Asst Dep Chief Fleet Support & Logistics M4
Asst Dep Chief Information Management & Technology M6
Asst Dep Chief Financial Management M8
Asst Dep Chief Research & Development M2
Asst Dep Chief Healthcare Operations M3
Asst Dep Chief Patient Safety, Clinical Quality, and High Reliability M5
Asst Dep Chief Operational Medicine & Capabilities Development M9

*Organizational Structure under current review and update

BUMED is an Echelon II Command which supports Echelon III Commands (Regional Commands), which in turn supports Echelon IV Commands (Navy Medical Readiness Training Commands). Most Medical Corps Officers reading this will ultimately report to the Commanding Officers of these Commands.

The Headquarters function of BUMED is organized as shown. The Medical Corps Chief serves as a direct advisor to the Surgeon General on matters pertaining to the Medical Corps. As special staff to the SG, the Medical Corps Chief's Office also works with the listed codes to advocate Medical Corps perspectives in the administration and management of BUMED policy.

Leadership Turnover - Meet your new Corps Chief

RDML James Hancock

A native of Illiopolis, Illinois, RDML Hancock enlisted in the Navy in 1982 serving in Navy nuclear power, he graduated from the U.S. Naval Academy in 1990, earning a Bachelor of Science in Engineering. Additionally, he holds a Doctor of Medicine from the Uniformed Services University of the Health Sciences (USUHS).

Operationally, RDML Hancock served as command flight surgeon, VMFA(AW)-332; group surgeon, Marine Aircraft Group 31 (forward) in support of Operation Noble Anvil; officer in charge, Marine Corps Air Station Beaufort Health Services; and officer in charge, Fleet Surgical Team 7/Commander Amphibious Group 1 surgeon/Task Force 76. Additionally, he served as task force surgeon, 2nd Battalion, 7th Marines where he developed and deployed the tactical trauma team concept, moving advanced resuscitative capabilities to the point of injury, and subsequently developed, tested, and deployed mobile trauma bays in support of Operation Enduring Freedom (OEF). His staff assignments include Command Surgeon, U.S. Fleet Forces Command and assistant deputy chief, medical operations, Bureau of Medicine and Surgery (BUMED).

RDML Hancock completed his family medicine residency at Naval Hospital Pensacola and an emergency medicine residency at Naval Medical Center Portsmouth. He served as staff physician and Director of Medical Services, Naval Hospital Beaufort; Director of Medical Services, Naval Medical Center Camp Lejeune; Deputy Commander, Naval Medical Center Portsmouth; and as Commanding Officer, Naval Medical Center Camp Lejeune, where he established the Navy's first trauma center. Additionally, as the Navy and Marine Corps representative to the Chairman of the Joint Chief of Staff Gray Team, he deployed multiple times in support of Operations Enduring and Iraqi Freedom, improving the policy and treatment of traumatic brain injury (TBI). Hancock's last staff tour was as Deputy Chief of Transition, BUMED.

RDML Hancock is currently serving as the Medical Officer of the Marine Corps / Director, Health Services, Headquarters, U.S. Marine Corps with additional duty as the 13th Chief of the Medical Corps.

RDML Hancock is qualified as a naval flight surgeon, fleet marine force medical officer, and surface warfare medical department officer. In addition to numerous unit and campaign awards, his personal awards include the Legion of Merit (four awards), Purple Heart, Meritorious Service Medal (four awards), Joint Service Commendation Medal, Navy and Marine Corps Commendation Medal (two awards), Navy and Marine Corps Achievement Medal (three awards), and the Combat Action Ribbon. Hancock maintains board certification with the American Board of Emergency Medicine and is a fellow of the American Academy of Emergency Medicine. His academic appointments include assistant professor of military/emergency medicine and assistant professor of neurology at USUHS.

Leadership Turnover - Meet your new Deputy Corps Chief

CAPT Joel Schofer

CAPT Schofer grew up in Southeastern Pennsylvania and attended Ursinus College (BS, 1997). He was commissioned as an Ensign in the Naval Reserves in 1997 and attended MCP Hahnemann School of Medicine (MD, 2001) on a Health Professions Scholarship. He was commissioned as an active duty Lieutenant in 2001 and completed his Transitional Year Internship at Naval Medical Center San Diego in 2002.

He then reported as a General Medical Officer with the United States Marine Corps, Camp Pendleton, California, where he deployed in support of Operation Enduring/Iraqi Freedom I. In 2003, he returned to Naval Medical Center San Diego and completed his Emergency Medicine Residency as Academic Chief Resident in 2006.

After residency, he served an overseas tour as an Emergency Physician at US Naval Hospital Okinawa, Okinawa, Japan, where he was a member of the Executive Committee of the Medical Staff and Chairman of the Provision of Care Committee. In 2009, he completed his Emergency Ultrasound Fellowship at Christiana Care Health System in Newark, Delaware.

CAPT Schofer worked as a Staff Emergency Physician at Naval Medical Center Portsmouth from 2009 to 2014. He served in a number of Emergency Department leadership roles including Emergency Ultrasound Director, Fast Track Director, and Senior Medical Officer. In addition, he served as an Associate Director of Medical Services and the Physician Advisor for Quality Management and Chairman of the Perfor-

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mance Improvement Committee on the Executive Committee of the Medical Staff. In 2010, he deployed with the 15th Marine Expeditionary Unit aboard the USS Pearl Harbor. In 2014, he graduated "with distinction" from the Naval Postgraduate School (MBA, 2014).

From 2014 to 2015, CAPT Schofer served as the Non-Surgical Detailer (PERS-4415R) in Medical Corps Assignments at Navy Personnel Command, Millington, Tennessee. While there he created Joel Schofer's Promo Prep and MCCareer.org, both highly regarded career -planning resources for Naval physicians.

From 2015 to 2016, CAPT Schofer served as the Commander of the Joint Medical Group and Joint Task Force Surgeon, Joint Task Force GTMO. In this role, he supervised 170 joint personnel providing care to over 2,100 military personnel and 107 detainees.

In 2018, he finished a three year tour as the Navy Emergency Medicine Specialty Leader. He led one of the largest communities in the Medical Corps, with over 270 physicians working in 15 Emergency Departments in the Department of Defense. In 2019, he concluded a three year tour at Naval Medical Center Portsmouth where he served as Executive Officer of Expeditionary Medical Facility – Juliet and the Associate Director and Director of Healthcare Business.

CAPT Schofer is board certified in Emergency Medicine and currently serves as the Deputy Chief of the Medical Corps at the Navy Bureau of Medicine and Surgery. He is a Certified Physician Executive, has over 200 professional publications and presentations, has held numerous national and state leadership positions, and has won national academic and educational awards. He holds an academic appointment as an Associate Professor of Military and Emergency Medicine at the Uniformed Services University of the Health Sciences. His military decorations include the Combat Action Ribbon, a Defense Meritorious Service Medal, two Meritorious Service Medals, and four Navy and Marine Corps Commendation Medals.

Plans and Policy Review: Navy Active Duty Delay for Specialists (NADDS)

Over the last year, I have gotten questions from members of our community who completed their residency training through the Navy Active Duty Delay for Specialists (NADDS) program about fluctuating promotion dates and concerns that they were somehow overlooked by a Reserve promotion board. I would like to explain some differences between the Active Duty and Reserve promotion boards, particularly with respect to selection for O-4, that explain the seeming inconsistency.

While you are in NADDS, you continue to accrue time in grade. For those starting as O-3s with longer residencies, those who are returning to residency after a GMO tour, or those with prior commissioned service, there is a high likelihood you will be "in zone" for selection to O-4 (or even O-5) while you are in a Reserve status. The first major difference between Reserve and Active Duty promotions is that there is no "below zone" look in the Reserves. The second major difference is the zone itself. The Active Duty zone for the Medical Corps is everyone from a given fiscal year; for example, for FY20, it was everyone with a Date of Rank (DOR) between Oct 1, 2013 and Sep 30, 2014. By comparison, the zone for the Reserve board was comprised of those with a DOR between July 1, 2013 and July 1, 2015. Zones for both components are published in a NAVADMIN that is normally released in December of the year prior to the selection board. As you can see, the Reserve zone comprises a much longer period of time as compared to the Active Duty zone, crosses FYs, and it also varies from year to year.

A third major difference is the selection percentage. The Active Duty O-4 board can select 100% of the number of people "in zone" (also known as all fully qualified). To illustrate, if there are 100 people in zone, the board can select all 100 of them; in reality, however, not all 100 are selected, and some number of people from the "above zone" and "below zone" competitive categories make up the delta. Conversely, the Reserve O-4 board is held to the "best and fully qualified" standard, so the promotion opportunity for O-4 is less than 100%. For FY20, it was 71%, or much more similar to the O-5 Active Duty promotion opportunity. Key take home point: the Reserve O-4 board is competitive – more on this later.

In the selection message, you are assigned an order of precedence based by your Reserve lineal number, which is a function of your DOR with respect to the DORs of everyone in your current grade. The order of precedence will ultimately determine your promotion date, which in turn is dictated by the Reserve promotion phasing plan for that fiscal year. The promotion phasing plan is published on the board page on the PERS website. In the event you promote before you return to Active Duty, things are relatively straightforward, although you may see your DOR adjusted once you are on active duty. Where it gets tricky is when you complete your training and come on Active Duty in a Select status. Unfortunately, your expected promotion date in the Reserves is highly unlikely to correspond to your expected promotion date

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Parting Thoughts…

CAPT Christopher Quarles received his Medical Degree in 1992 and commissioned into the Navy on a 2-year HPSP scholarship. After completing a Family Medicine internship at NH Bremerton he served as the GMO aboard the USS Sacramento (AOE 1). He then completed his Family Medicine Residency at Bremerton and completed utilization tours at La Maddalena, Italy and Newport, RI. His subsequent tours were as the Senior Medical Officer of the USS Blue Ridge (LCC 19) and Director of Medical Services, first at NH Rota and then NH Jacksonville. While at Jacksonville, he deployed as an Individual Augmentee in support of Operation Enduring Freedom as the Medical Director for the Afghan National Police Embedded Training Team. Subsequently, he was the Executive Officer at NH Pensacola and then the Commanding Officer of NH Bremerton. He then served as the 5th Fleet Surgeon (Bahrain) and finally served as the Deputy Chief of the Medical Corps. He will be retiring in November 2019 after 27 years of service. We were fortunate enough to sit down and ask him a few questions as he reflects on his career and experiences...

Which tour did you find most rewarding?

There is nothing quite like being a Commanding Officer. It is not the title that makes it appealing, it is the unparalleled opportunity to advocate for, promote and cheer for your staff that makes command special. From a physician perspective, both my ship tours were especially rewarding. They are unique settings suited for a primary care doc. From a family standpoint, Rota is the tour the kids still talk about the most, closely followed by Yokosuka. Now anyone that knows me, knows that our favorite duty station will always be Bremerton and the Pacific Northwest.

Were there any mid-career opportunities you wished you'd taken advantage of?

I am very happy with the diversity within my career. If I had it to do over again, I might have tried harder to go to War College and I definitively would have found a way to serve with the Marines.

Any advice for senior officers seeking command?

Navy Medicine will continue to need physicians to lead and help shape our future organization to meet operational requirements (frankly, the Navy could not do without us). There will be many opportunities to lead – as a clinician, as a researcher, as a teacher, and in operational settings. My advice for those seeking command – be all in. Command is a blessing but being accountable and responsible for an entire organization is not for the faint of heart. It is natural to have doubts when considering a new job, but if you have persistent concerns, examine those closely before going forward. At all levels, the reluctant leader who serves out of a sense of obligation but isn't all in, will likely struggle. Additionally, have faith in our system. After either being subject to or part of the slating process these last 9 years, our screening and slating process is inherently fair for all the Medical Department Corps and does a good job of matching officers and assignments.

Did you receive any advice or mentorship that particularly resonated through your career?

Best advice I ever got – "be yourself". Those qualities that make you stand out and get noticed by your leadership today are the same you need to be an effective leader tomorrow. Having said that, very few are 'natural' leaders. Great leaders show a sustained commitment to learning, continue to develop and adapt their leadership skills, and have the ability to apply lessons

CAPT Christopher Quarles

learned from constructive criticism.

How was your transition from primary clinical care to executive leadership?

For me, there was no abrupt internal switch for the transition from staff physician to "leader". There was a conscious decision as a junior officer to get involved. If I am being honest, there was also some desire for self-determination (at least the perception that I had control!) For me, the transition began with my wanting to improve things in my department and then my directorate and then the command and one leadership job lead to the next. For physicians, there is an innate ability to identify problems that likely stems from our training and experience. For physician leaders, you have to make the decision to stop throwing rocks (identifying what is broken) and make the decision to help fix problems to improve the command's ability to meet its mission.

Any other pearls you'd like to leave us with?

The next 3 to 5 years will be filled with transition and some uncertainty as we evolve into what is next. There will be robust opportunities for you to help the organization get it right. Be an advocate for your patient, your peers, and those you lead and everything will be ok, promise!

USS Sacramento (AOE-1) Photo: Petty Officer Cross

USS Blue Ridge (LCC-19) Photo:Petty Officer Behnke

Congratulations to the next generation of Navy Physician Leaders!

Commanding Officers:

CAPT Reginald Ewing
NMRTC Camp Lejeune

CAPT Teresa Allen
NMRTC Jacksonville

CAPT Thomas Nelson
NMRTC Great Lakes

CAPT Christopher Tepera
NMRTC Pearl Harbor

CAPT Raymond Batz
NMRTC Beaufort

CAPT Carolyn Rice
NMRTC Yokosuka

CAPT Timothy Quast
USNS MERCY

CAPT John Gilstad
Navy Medical Research Command

Executive Officers:

CAPT(s) Melissa Austin
NMRTC Portsmouth

CAPT Sean Hussey
Tripler Army Medical Center

CAPT Bryan Spalding
NMRTC Patuxent River

CAPT Stephen Arles
NMRTC Corpus Christi

CAPT David Barrows
NMRTC Jacksonville

CAPT Jeffrey Feinberg
NMRTC Bremerton

CAPT(s) Anja Dabelic
NMRTC Guantanamo Bay

CAPT Kimberly Toone
USNS COMFORT

CAPT Michael Penny
NATO Role III, Kandahar (Spring)

CDR Linda Smith
NMRU San Antonio

Chief Medical Officer:

CDR David Weis
NMRTC Great Lakes

CDR Matthew Matiasek
Fort Belvoir Community Hospital

CDR April Breeden
NMRTC Pearl Harbor

CDR James Ripple
NMRTC Lemoore

CAPT Frank Axelsen
NMRTC Patuxent River

CAPT Mark Woodbridge
NMRTC Camp Lejeune

CAPT Cary Harrison
Navy Medicine East

CAPT Gray Dawson
Navy Medicine West

CDR Brett Chamberlin
U.S. NMRTC Guam

CDR(s) Christopher Helman
U.S. NMRTC Guantanamo Bay

Officer in Charge:

CAPT Georgia Stoker
Naval Aerospace Medical Institute

Command and Milestone Billets - How the process works...

Leadership at junior levels is largely a function of local competition and placement by detailers. As scope of responsibility increases, the selection and placement of senior leaders occurs in a deliberate process known as 'the slate.'

The slating process is two-fold. First, officers must be 'screened', or identified as having sufficient experience and potential for leadership. This occurs through a records screen at Navy Personnel Command to ensure officers have demonstrated success in a variety of billets and are adequately prepared for senior leadership. For Command Screening, this process also involves a challenging interview process. An officer's entire professional record is reviewed and results in a binary decision as to whether they are eligible to be slated into a milestone or command billet.

From there, the list of eligible officers is forwarded to the Corps Chiefs Office. The four deputy Corps Chiefs meet regularly to identify the initial slate. This recommendation is the first draft of who will be selected as a Commanding Officer, Executive Officer, Chief Medical Officer, or Officer-in-Charge. They also recommend billet assignments to ensure the best fit for each given Command.

This recommendation is forwarded to the Council of Corps Chiefs, comprised of the representing admiral in each corps. The Council of Corps Chiefs further deliberates leadership assignment and forward their recommendation to the Surgeon General. At this point, the Surgeon General considers the recommendations and may make changes as necessary. Once signed, the Slate becomes official and the next generation of leaders are notified.

PERS Pearl…. Officer Photographs

Officers now have a simplified way to submit their official photographs to their Official Military Personnel File (OMPF) through MyNavy Portal (MNP). Navigate to https://my.navy.mil, go to "MyRecord," "Other Record Sites of Interest," and there the "Officer Photograph" tile can be found. When clicked, an electronic Officer Photograph form (NAVPERS Form 1070/884) opens and photos can be uploaded directly into the form and then submitted to the OMPF. Along with this new capability, the new Officer Photograph form will require members to use their DOD ID rather than their Social Security Number. A tutorial for this new application can also be found on MNP under the Officer Photograph link. Traditional mailed submissions remain acceptable as an alternative.

Reference: https://www.navy.mil/submit/display.asp?story_id=109571?utm_source=in_focus&utm_medium=photosonline&utm_campaign=09_20_19

HPSP RECRUITING NEEDS YOUR HELP

The Corps Chief's Office has received numerous inquiries regarding the Hometown Hero Initiative. This program relies on the initiative of our own physicians to create engagement opportunities with their alma mater's, hometowns, or other medical groups to help spread awareness regarding opportunities in the Navy Medical Corps and the HPSP scholarship. Commanding Officers have been encouraged to authorize permissive TAD (Free Leave!) to physicians who help the recruiting mission. Most physicians will do so by meeting with interested applicants or premedical groups. The best part of the Hometown Hero Initiative is it is completely up to the individual to create, although they can do so by connecting with local recruiters. For assistance in locating a recruiter, please email MedicalVIP.fct@navy.mil. Please note that there is a separate 'High-Yield Initiative' in which the Corps Chief's Office is looking to engage the top 10 undergraduate premedical programs and may be associated with travel funding. Information regarding this has been distributed via specialty leaders and more information will be forthcoming.

(Continued from page 7, Plans and Policy)

on Active Duty. Why, you ask? Let me explain. Once you are on Active Duty, you are assigned a new lineal number specific to the Active component. That new lineal number can make you either more or less senior within your promotion peer group, and this in turn affects where you fall in the promotion phasing plan. Some people are promoted earlier than they expect, and some are promoted later. To make it even more confusing, all of these adjustments can take time to wind their way through the PERS system – sometimes months – so a small number of people will find out they have been promoted months after the fact.

As Whitney Houston sang so eloquently, "How will I know?" The best advice is to watch the monthly promotion NAVADMIN for your name. Expect September 1, and hope it is earlier, recognizing that you may all of a sudden see your name on the monthly NAVADMIN with a date of rank months prior. If so, do your happy dance, head to the uniform shop, and check your LES religiously for back pay (it will eventually happen). Ultimately, even if you've gone line-by-line through the lineal list and think you know where you fall on the Active Duty order of precedence, you still need to watch the NAVADMINs. The promotion list is a living document; people enter and exit Active Duty throughout the year, and this can impact your place on the list enough to change your month of promotion. Keep this in mind if/when you are planning festivities.

Now, back to that competitive thing. If you want to be picked up in zone in the Reserves, you will need to pay attention to your record. Make sure it is as up to date as it can be. Even if you are getting "Not Observed" FITREPs, make sure your accomplishments are described in Block 41, at least until we transition to the new FITREP system. Write a letter to the board to highlight anything you have done that isn't reflected in your record, along with the fact that you are coming back to Active Duty. Some people also suggest getting a letter of recommendation from a senior leader in your community who is on active duty, but if you do this, please make sure it is a letter of quality and not simply a summary of your CV by someone who does not know you well.

(Junior Operational Spotlight, Continued from page 2)

anesthesiologists and 4 CRNAs) to provide safe, reliable, and efficient anesthesia services."

The 5-month deployment calls for 12 mission stops in countries located in South America, Central America, and the Caribbean. Each mission stop begins with the surgery and anesthesia teams going ashore to screen patients. "We have somewhat strict parameters for which patients we can treat." Due to the nature of the mission, patients with significant cardiac histories, obesity or other significant comorbidities are de-screened for surgery aboard the Comfort. "We are fortunate to have a pediatric anesthesiologist and a critical-care anesthesiologist on the team. Their presence really allows us to take on a slightly more complex patient population." Surgical screening day is followed by 6 days of operations. "I really enjoy the operative days because I am able to use my training as an Anesthesiologist and impact patient's lives for the better." After operations have been completed and patients have left the ship, the Comfort sets sail to the next destination. The hospital ship has over 1,000 inpatient beds, 3 ICUs, 12 operating rooms and 2 CT scanners, to name a few of its capabilities. Embarking with multiple medical officers with different specialties allows for multi-disciplinary collaboration. The surgical assets for Enduring Promise 2019 include general surgeons, a pediatric surgeon, urologist, ophthalmologist, orthopedic surgeon, and a plastic surgeon. The medical specialties include radiologists, emergency physicians, pediatricians and internists.

"We just completed our 7th of 12 mission stops and have performed more than 700 surgical procedures. Our plastic surgeon and oral maxillofacial surgeons have performed multiple cleft lip/palate repairs, the general surgery team has performed over a hundred laparoscopic cholecystectomies and hernia repairs, and the ophthalmologists have fixed hundreds of cataracts." Every mission stop, the ship receives multiple distinguished visitors, including Vice President Pence, and the Presidents of Panama and Colombia.

The USNS Comfort will continue on with the remainder of her mission, spreading hope and aid to several more Caribbean countries before returning to port in Norfolk, Virginia. Although the mission will soon come to an end, the legacy of humanitarian aid, hope, and Comfort, will continue to endure.

Accessing the Corps Chief Homepage (if unable to hyperlink directly)

- Go to www.med.navy.mil
- Click on 'Internal Site (CAC Enabled)' located on the top banner, far right (next to facebook, twitter icons)
- Select either hyperlink option to access BUMED Sharepoint (the second option for 'non-navy medicine' is more reliable if outside the DHHQ network). Use your CAC EMAIL certificate for access.
- Click the 'Surgeon General' dropdown menu located on the top banner and select 'M00C– Corps Chiefs'
- Click on 'Corps Sites' dropdown menu located on the top banner and select 'Medical Corps (M00C1)'
- Bookmark this site and please visit regularly for updates!

Medical Corps Challenge Coins

High-quality 1.75" coin with classic front and contemporary back, a wonderful memento, gift, or token of appreciation:

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Please email **CAPT William Beckman <william.a.beckman.mil@mail.mil>** with the following information:

- **Order quantity**
- **Good mailing address (home is best)**
  - FPO AE/AP must include zip+4 & local phone for US Customs form

Once email is received, CAPT Beckman will confirm order, and advise of exact amount due, as well as specific check payment information (sorry, no credit card/PayPal option).

For further assistance, please feel free to contact us directly...

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